FOR BOARD OF HEALTH USE ONLY			
Date Received	Date Inspected	Approved By	Permit # Issued

THE COMMONWEALTH OF MASSACHUSETTS

TOWN OR CITY OF _____

Food Establishment Permit Application

(Application must be submitted at least 30 days before the planned opening date)

1. Establishment Name:	
2. Establishment Address:	
3. Establishment Mailing Address (if different):	
4. Establishment Telephone No:	
5. Applicant Name & Title:	
6. Applicant Address:	
7. Applicant Telephone No:	24 Hour Emergency No:
8. Owner Name & Title (if different from applicant):	
9. Owner Address (if different from applicant):	

10. Establishment Owned By:	11. If a Corporation or Partnership, give name, title, and home address of officers or partner.
☐ An Association ☐ A Corporation ☐ An Individual ☐ A Partnership ☐ Other Legal Entity_____	Name Title Home Address _____ _____ _____ _____

12. Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager, etc.)	
Name & Title:	
Address:	
Telephone No:	
Emergency Telephone No:	Fax:

13. District or Regional Supervisor *(if applicable)*	
Name & Title:	
Address:	
Telephone No:	Fax:

Food Establishment Information

14. Water Source: DEP Public Water Supply No.: *(if applicable)*	15. Sewage Disposal:
16. Days and Hours of Operation:	17. No. of Food Employees:
18. Name of Person In Charge Certified in Food Protection Management: *Required as of 10/1/2001 in accordance with 105 CMR 590.003(A) Please attach copy of certificate.*	
19. Person Trained in Anti-Choking Procedures (if 25 seats or more): ☐ Yes ☐ No	

20. Location *(check one)*	22. Establishment Type (check all that apply)	
☐ Permanent Structure ☐ Mobile	☐ Retail (Sq. Ft.) ☐ Food Service – (Seats) ☐ Food Service – Takeout ☐ Food Service – Institution (Meals/Day) Other (Describe)	☐ Caterer ☐ Food Delivery ☐ Residential Kitchen for Retail Sale ☐ Residential Kitchen for Bed and Breakfast Home ☐ Residential Kitchen for Bed and Breakfast Establishments ☐ Frozen Dessert Manufacturer
21. Length Of Permit: *(check one)* ☐ Annual ☐ Seasonal/Dates: _____ ☐ Temporary/Dates/Time:		

23. Food Operations: *(check all that apply):*

Definitions: *PHF – potentially hazardous food (time/temperature controls required)*
Non-PHF's – non-potentially hazardous food (no time/temperature controls required)
RTE – ready-to-eat foods (Ex. sandwiches, salads, muffins which need no further processing)

☐ Sale of Commercially Pre-Packaged Non-PHF's	☐ PHF Cooked To Order	☐ Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service.
☐ Sale of Commercially Pre-Packaged PHF's	☐ Preparation Of PHFs For Hot And Cold Holding For Single Meal Service	☐ PHF and RTE Foods Prepared For Highly Susceptible Population Facility
☐ Delivery of Packaged PHFs	☐ Sale of Raw Animal Foods Intended to be Prepared by Consumer.	☐ Vacuum Packaging/Cook Chill
☐ Reheating of Commercially Processed Foods For Service Within 4 Hours.	☐ Customer Self-Service	☐ Use Of Process Requiring A Variance And/Or HACCP Plan (including bare hand contact alternative, time as a public health control)
☐ Customer Self-Service Of Non-PHF and Non-Perishable Foods Only.	☐ Ice Manufactured and Packaged for Retail Sale	☐ Offers Raw Or Undercooked Food Of Animal Origin.
☐ Preparation Of Non-PHF's	☐ Juice Manufactured and Packaged for Retail Sale	☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service
	☐ Offers RTE PHF in Bulk Quantities	
	☐ Retail Sale of Salvage, Out of Date or Reconditioned Food	

To be completed by the Board of Health

Total Permit Fee: _____
Payment is due with application

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the Board of Health on how to obtain copies of 105 CMR 590.000 and the Federal Food Code.

24. Signature of Applicant: _____

Pursuant to MGL Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid state taxes required under law.

25. Social Security Number or Federal ID: _____

26. Signature of Individual or Corporate Name: _____

Print Form

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date: _____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #** _____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ **Phone #:** _____